Medical History and Social Service Questionnaire

Patient Name: ____ Social Security Number : ________________________
Occupation: ________________________________ Reason for Referral: ____________________________________
Emergency Contact Name/Relation: ____________________________ Phone Number: _______________________

Was Surgery Performed Y or N Type of Surgery ___________________________ Date of Surgery _____/_____/_____

Pain Level (0-10) 0 = No Pain 10 = Extreme Pain Current _______ At Rest _______ With Activity _______

Medications

Anti Inflammatory Y or N Muscle Relaxers Y or N Pain Medication Y or N
Other Medications ____
____

Rehabilitation Services - Please circle if you have had any of the following Medical or Rehabilitation Services for **THIS** Injury

General Practitioner	Orthopedist	MRI	Results ______________________
Neurologist	Podiatrist	X-Rays	Results ______________________
Chiropractor	Emergency Room	CT Scan Results ______________________	
Arthrogram Results ______________________		EMG/NCV	Results ______________________
Physical Therapy Y or N	When ? ______________________		Where ? ______________________

Past / Present Conditions

Respiratory Problems	Y or N	Headaches	Y or N
Shortness of Breath	Y or N	Nausea	Y or N
Chest Pain/Heart Disease	Y or N	Dizziness or Fainting	Y or N
Do you have a Pacemaker	Y or N	Numbness or Tingling	Y or N
Heart Attack	Y or N	Muscle Weakness	Y or N
Heart Surgery	Y or N	Weight Loss/Energy Loss	Y or N
Irregular Heartbeat	Y or N	Sleeping Difficulty	Y or N
Stroke / TIA	Y or N	Emotional/Pyschological Problems	Y or N
Parkinson's Disease	Y or N	Multiple Sclerosis	Y or N
Epilepsy / Siezures	Y or N	Arthritis Osteo / Rheumatoid	Y or N
Infectious Diseases	Y or N	Bowel or Bladder Problems	Y or N
Diabetes IDDM / NIDDM	Y or N	Any falls in the past 12 months	Y or N
Cancer / Chemotherapy	Y or N	Osteoporosis	Y or N
Type of Cancer ____________________________		Allergies	Y or N
High Blood Pressure	Y or N	Do You Smoke?	Y or N
Hearing Difficulty	Y or N	Are You Pregnant?	Y or N
Vision Difficulty	Y or N	Any Pins or Metal Implants?	Y or N

Past Two Surgeries
Type ____________________________________ Date (Mo./Yr.)____________________
Type ____________________________________ Date (Mo./Yr.)____________________

Other Relevant Conditions:____

As a component of our participation in the Medicare program, we have partnered with a professional who can provide social services to our clients and can assist them in exploring community resources available to obtain the basic necessities for living. Do you have difficulty with any of the following **as a result of your current medical condition** ?

Obtaining food or medicine	Y or N	Paying rent / utilities	Y or N
Transportation	Y or N	Safety Issues at home	Y or N
Coping with current condition	Y or N	Financial Stress	Y or N

Other ____

Do you feel that you require any assistance from a social worker while enrolled in therapy ? Y or N

Patient / Guardian Signature ____________________________________ Date ______/______/______
Therapist Signature (reviewed form with pt.) ________________________________ Date _______/_______/_______
Date social worker contacted _______/_______/_______ Therapists Initials _________